K. Expanded Coverage of Children under Medicaid and Medicaid Coordination

The proposed regulations discussed in this subsection are changes to Medicaid regulations found in parts, 433, and 435. These rules apply to Medicaid only.

Section 2101 of the Act requires that States coordinate child health assistance under title XXI with other sources of health benefits coverage for children. Section 2102(b)(3)(B) of the Act requires that children found through the SCHIP screening process to be potentially eligible for Medicaid under the State's Medicaid plan shall be enrolled for such assistance.

Section 4911 of the BBA, amended by section 162 of the DC Appropriations Act, Public Law 105-100, enacted on November 19, 1997, established a new optional categorically-needy eligibility group known as "optional targeted low-income children." The law provides for an enhanced Federal matching rate for Medicaid services provided to children eligible under this group. The BBA also provides for States to receive this enhanced Federal matching rate for services to children who meet the definition of "optional targeted low-income children" and whom the State covers by expanding an existing Medicaid eligibility group (for example, poverty-related children). "SCHIP" itself is not a new or separate Medicaid eligibility group. A State that implements a Medicaid expansion program under SCHIP, may expand eligibility to

the new optional Medicaid eligibility group just mentioned, expand eligibility to optional targeted low-income children through expanding an existing Medicaid eligibility group, or implement a combination of the two options. We note that Medicaid expansion programs are subject to all the rules and requirements set forth in title XIX of the Act and its implementing regulations, and the State Medicaid plan. Section 4912 of the BBA added a new section 1920A to the Act to allow States to provide Medicaid services to children during a period of presumptive eligibility.

In addition to modifications to the proposed regulations made in response to the comments discussed below, we have amended part 436 of this subchapter to reflect the changes made by the BBA to eligibility for Medicaid in Guam, Puerto Rico and the Virgin Islands. The changes made to part 436 by these regulations mirror those made to part 435, governing Medicaid eligibility in the States, District of Columbia, the Northern Mariana Islands and American Samoa. Specifically, new §436.3 corresponds to new §435.4; modifications to §§436.229, 436.1001 and 436.1002 correspond to the modifications made to §§435.229, 435.1001 and 435.1002; and new §§436.1100-1102 correspond to new §§435.1100-1102. Our failure to amend part 436 in the proposed rules was an oversight. There are no distinctions in policy or requirements with respect to the regulations pertaining to the

States, District of Columbia, the Northern Mariana Islands and American Samoa versus those pertaining to Guam, Puerto Rico and the Virgin Islands. And any changes made to the proposed rules pertaining to expanded coverage of children under Medicaid and Medicaid coordination in these final regulations are also reflected in the amendments to part 436. We received a number of general comments on this subpart and one comment relating to the screen and enroll requirements set forth in subpart C which is relevant to this section. We will address these comments below.

1. General comments

Comment: With respect to the screen and enrollment requirements of section 2102(b)(3)(B) of the Act, two commenters recommended that the regulations require that, even if a separate application for a separate child health program (as opposed to a joint application with Medicaid) is used, the application form and any supporting verification must be transmitted to the appropriate Medicaid office for processing without further action by the applicant to initiate a Medicaid application. One commenter recommended that if an applicant for a separate child health program, who has been determined potentially eligible for Medicaid, is to be required to take any additional steps in order to apply for Medicaid, the Medicaid agency must inform the family of the action required.

Response: The obligations of the State agency or contractor responsible for determining eligibility for a separate child health program with respect to the requirement that children screened potentially eligible for Medicaid be enrolled in that program are discussed in the preamble to subpart C and are set forth in §457.350 of the final regulations.

We have added a new §431.636 to clarify the obligations of the State Medicaid agency with respect to the screen-and-enroll requirement. Specifically, we have added this section to require that State Medicaid agencies adopt procedures to complete the Medicaid application process for, and facilitate the enrollment of, children for whom the Medicaid application and enrollment process has been initiated pursuant to §457.350(h)(2) in subpart C of these regulations. Such procedures shall ensure (1) that the Medicaid application is processed in accordance with the regulations governing eligibility for Medicaid in the States and District of Columbia, 42 CFR part 435 or the regulations governing Medicaid eligibility in Guam, Puerto Rico and the Virgin Islands, 42 CFR part 436, as appropriate; and (2) that the applicant is not required to provide any information or documentation that has been provided to the State agency or contractor responsible for determining eligibility under the State's separate child health program and forwarded by such

agency or contractor to the Medicaid agency on behalf of the child pursuant to §457.350(h)(2) of this subchapter.

When a State Medicaid agency receives an application--either a joint SCHIP-Medicaid application or separate Medicaid application--for a child screened potentially eligible for Medicaid, the application must be processed in accordance with title XIX, Medicaid regulations, and the State plan. If the Medicaid agency has all the information it needs to process the Medicaid application, no further follow-up is needed until the State is ready to make a final eligibility determination. If additional information is needed, the agency must contact the family and explain what is needed to complete the Medicaid application process.

If a separate application is used, the State Medicaid agency should promptly follow up with the family as soon as it receives information about the child. If the family has not already completed a Medicaid application, the Medicaid agency should provide the family with an appropriate application and inform the family about any additional steps that must be taken or additional information which must be provided in order to complete the Medicaid application process.

Comment: We received a number of comments urging HCFA to seek statutory changes expressly authorizing more flexibility for States. The suggested changes include allowing States more

flexibility under presumptive eligibility and a longer period of presumptive eligibility, and giving States the option of establishing their own filing unit rules by eliminating the prohibition on deeming income from anyone other than from a parent to a child or a spouse to a spouse.

Response: We will take these suggestions into consideration in developing future legislative proposals.

Comment: One commenter also suggested that States be allowed to ?out-source" (privatize) Medicaid eligibility determinations.

Response: We have previously considered requests by States to privatize Medicaid eligibility determinations. Medicaid policy requires that most activities included in the eligibility determination process be performed by employees of a public agency. Therefore, we do not have the discretion to allow States to "out source" Medicaid eligibility determinations.

Comment: One commenter indicated that the regulations should clarify that, if a State chooses to provide continuous eligibility under section 1902(e) of the Social Security Act, as added by section 4731 of the BBA, it must provide continuous eligibility for all children who are eligible for Medicaid.

Response: These regulations do not address changes made by the BBA that are not directly related to title XXI. A separate

Notice of Proposed Rulemaking will be published addressing other changes made by the BBA to the Medicaid program.

Comment: One commenter noted that, for new eligibility groups, States often have no eligibility determination experience and may be reluctant to ease the documentation and verification requirements for fear of increasing the error rate under the Medicaid eligibility quality control (MEQC). Two organizations supported waiving MEQC errors for new eligibility groups created by PRWORA, which we explained in the preamble to the proposed rule we would be willing to do. One State asked if the MEQC waiver of errors extended to the section 1931 group or to child-only groups.

Response: Section 1903(u) of the Act, which provides the statutory basis for MEQC, does not give HCFA the authority to grant a grace period for eligibility errors. However, the statute does provide that a State can request a waiver of a Federal financial disallowance relating to eligibility errors on the basis that it made a good faith effort to meet the 3-percent error rate limit. Implementing regulations at 42 CFR 431.865 include sudden and unanticipated workload changes that result from changes in Federal law as an example of circumstances under which HCFA may find that a State made a good faith effort. Under this authority, we have offered in the past to waive errors in cases of pregnant women and infants that occurred during the

first 6 months in which States were implementing a new Federal law mandating coverage of these groups (the Medicare Catastrophic Coverage Act of 1988). Our intent in offering this waiver was to encourage States to expand coverage to pregnant women and infants without the concern of fiscal penalties. It also allowed States time to develop the experience necessary to accurately determine Medicaid eligibility for these new groups.

We recognize that the sweeping changes in law brought by welfare reform and title XXI presented similar opportunities as well as many challenges to States. The PRWORA of 1996 established a new eligibility category for families with children, which is not linked to welfare. The BBA of 1997 established a new coverage group for children and established an enhanced match rate to encourage expanded coverage of children under this new group or other existing Medicaid groups. HCFA has encouraged States to take advantage of the title XXI funds to expand coverage for children, and we have encouraged States to simplify their enrollment procedures to reduce barriers to participation for all Medicaid-eligible children and their families. As we explained in the preamble to the proposed rule we would waive MEQC eligibility errors attributable to the coverage of these new and expanded groups of children and families. Our intent is to give States the opportunity to gain experience in making accurate eligibility determinations for

these newly covered children without relying on lengthy applications or requiring excessive eligibility verification requirements due to State concern with fiscal penalties.

Although we are making MEQC waivers available, States are unlikely to face MEQC fiscal penalties. States have maintained a national error rate below 2-percent for over ten years. In addition, welfare reform implementation problems have resulted in eligible children and families being denied or terminated from Medicaid rather than ineligible children and families being enrolled in Medicaid. MEQC errors arise when a State makes erroneous payments. There are likely very few cases in which such erroneous payments have been made due to section 1931 implementation.

Finally, we have encouraged States to develop alternative MEQC programs because this option can be a particularly effective means of focusing on error-prone areas. Thirty-one States are currently operating alternative MEQC programs either as pilots or as part of a section 1115 waiver (most since 1994). For the duration of the pilot or section 1115 waiver, the error rates for these States are frozen at below 3 percent, and the States are not subject to disallowances.

In terms of the scope of the waiver, we agree with the comment that any waiver should apply to the section 1931 group as well as other groups pertaining to children. Therefore, we have

determined that we should grant a MEQC waiver for eligibility errors directly attributable to the implementation of: (1) coverage for children and families determined eligible after October 1, 1996 for Medicaid under section 1931 or section 1925 of the Act;(2) coverage for children determined eligible after October 1, 1997 for Medicaid under the optional group of targeted low-income children under age 19 (or reasonable groups of these children) who are otherwise ineligible for Medicaid, have a family income below a certain State-specified level and have no health insurance (see section 1902(a)(10)(A)(ii) of the Act); and (3) coverage of children determined or redetermined eligible for Medicaid after October 1, 1997 whose disabled status is protected under section 4913 of the BBA. This waiver does not apply to children covered under separate child health programs because the MEQC process does not apply to such programs.

We are limiting the waivers to one year beginning with the publication date of this final rule rather than the first year of implementation of the legislation as we did previously with new coverage of pregnant women and infants. In recent months, we have learned that many States still need to adapt their systems to assure that children eligible for Medicaid under section 1931 receive Medicaid. Thus, at this point, limiting the waivers to one year after implementation of the statute would not accomplish the intended purpose. Since many States are still expanding

coverage to children and are adopting new approaches to simplify their eligibility and redetermination procedures, waivers effective for one year following the promulgation of these regulations should enable States to finish updating their systems to ensure effective implementation of section 1931 eligibility without incurring financial penalties as they do so. The incidence of erroneous Medicaid denials and terminations should diminish as States gain experience, and that MEQC waivers should encourage States to move quickly to make the changes necessary to determine eligibility consistent with the requirements of the law.

Because the regulations currently provide the basis for waiver requests and the good faith waiver process is administrative in nature, it is not necessary to amend regulations at 42 CFR 431.865 to include this specific waiver exclusion. In the unlikely event that a State experiences an error rate above 3 percent over the next year, we will provide that State with instructions for applying for a good faith waiver.

Comment: One commenter expressed strong support for the conclusion that all Medicaid rules, including those related to EPSDT, apply to Medicaid expansion programs.

Response: We appreciate the support. A State that expands eligibility for children under Medicaid must apply all the title

XIX rules to the expansion population including children for whom the State receives enhanced FMAP at the title XXI rate.

2. Disallowance of Federal financial participation for erroneous State payments (§431.865)

We proposed to amend §431.865(b)to exclude from the definition of "erroneous payment" payments made for care and services provided to children during a period of presumptive eligibility. We received no comments on this section and are implementing it as proposed. We are, however, also making a technical amendment to the definition of erroneous payment in §431.865(b). Specifically, we are changing the word "in" in paragraph (1) to "if" so that the definition reads: "*Erroneous payments* means the Medicaid payment that was made for an individual or family under review who--(1) Was ineligible for the review month or, if full month coverage is not provided, at the time services were received." The use of "in" instead of "if" clearly was a typographical error.

3. Rates of FFP for program services (§433.10)

We proposed to add a new paragraph (c)(4) to state that the FFP for services provided to uninsured children under an SCHIP Medicaid expansion program would be the enhanced FMAP established by SCHIP. We received no comments on this section and are implementing it as proposed.

4. Enhanced FMAP rate for children (§433.11)

Section 4911 the BBA, as amended by section 162 of Public Law 105-100, authorized an increase in the Federal medical assistance percentage (FMAP) used to determine the Federal share of State expenditures for services provided to certain children. Federal financial participation for these children will be paid at the enhanced FMAP rate determined in accordance with §457.622, provided that certain conditions are met. The State's allotment under title XXI will be reduced by payments made at this enhanced FMAP, consistent with §457.616.

Under proposed §433.11(b) in order to be eligible to receive Federal payments at the enhanced FMAP, a State must:

(1) Not adopt income and resource standards and methodologies for determining a child's eligibility under the Medicaid State plan that are more restrictive than those applied under the State plan in effect on June 1, 1997;

(2) Have sufficient funds available under the State's title XXI allotment to cover the payments involved; and

(3) Maintain a valid method of identifying services eligible for the enhanced FMAP.

Under §457.606, the State must also have an approved State plan in effect. For purposes of determining whether an income or resource standard or methodology is more restrictive than the standard or methodology under the State plan in effect on June 1, 1997, we proposed to compare it to the standard or methodology

that was actually being applied under the plan on June 1, 1997. For purposes of this section, a pending Medicaid State plan amendment that would establish a more restrictive standard or methodology, but that has an effective date later than June 1, 1997, would not be considered "in effect" on June 1, 1997, regardless of when it was submitted. However, while States that adopt more restrictive income or resource standards or methodologies than those in effect on June 1, 1997 would not be eligible for enhanced FMAP, the proposed rule provided that if a State drops an optional eligibility group entirely, the prohibition against receiving enhanced FMAP does not apply.

In §433.11, we proposed that the enhanced FMAP would be used to determine the Federal share of State expenditures for services provided to three categories of children. The first category for whom the enhanced FMAP would be available in the proposed rule was the new group of "optional targeted low-income children" described in proposed §435.229. Under this category, the State would expand eligibility to a new group of children.

Under the second category the State would cover children who meet the definition of "optional targeted low-income child" by expanding coverage under existing Medicaid groups. Thus, a State would not need to adopt the new eligibility group of optional targeted low-income children in order to receive the enhanced match. As long as the newly-covered children under an expanded

Medicaid group met the definition of targeted low-income child, including the requirements that they be uninsured and not eligible for Medicaid under the State plan in effect on March 31, 1997, the State could receive the enhanced match for them. (Note that the State could claim the regular FMAP for children covered by an expansion, who do not meet the definition of optional targeted low-income children because they are covered by private insurance.) These first two categories of children are reflected in proposed §433.11(a)(1), which implements sections 1905(u)(2)(C) and 1902(a)(10)(A)(ii)(XIV) of the Act.

The third category for whom the State may receive the enhanced FMAP consists of children born before October 1, 1983 who would not be eligible for Medicaid under the policies in the Medicaid State plan in effect on March 31, 1997, but to whom the State subsequently extends eligibility by using an earlier birth date in defining eligibility for the group of poverty-level-related children described in section 1902(l)(1)(D) of the Act. The enhanced FMAP is available for services to children in this third category even if they have creditable health insurance, as defined at 45 CFR 146.113. We note that, as the statutory phase-in of poverty-level-related children under age 19 proceeds, the numbers of children in this third category will diminish; by October 1, 2002, all the children in this category will be included in the mandatory group of children described in section

1902(l)(1)(D) of the Act, and State spending for services to them will be matchable at the State's regular FMAP.

Concerning the second category above, it is unlikely that Congress intended to provide enhanced FMAP for services provided to children who, although not eligible under the policies in effect in the Medicaid State plan in effect on March 31, 1997, became eligible after that date due solely to a Federal statutory change or an already scheduled periodic cost-of-living increase. These types of changes are inherent in the State plan policies in effect on March 31, 1997. Enhanced FMAP will be available only when children are made eligible due to a change in State policy, which expands eligibility to cover previously ineligible children.

Federal payments made at the enhanced FMAP rate reduce the title XXI appropriation in accordance with section 2104(d) of the Act. Thus, HCFA must apply such payments against a State's title XXI allotment until that allotment is exhausted. After the title XXI allotment is exhausted, expenditures will be matched at the State's regular FMAP rate.

Comment: Three commenters objected to our proposal to allow a State to receive enhanced FMAP if the State drops an optional eligibility group that was covered on March 31, 1997 because the maintenance of effort provision in the statute was intended to prevent States from dropping Medicaid coverage in order to put

children in a separate child health program. The commenters argued that our proposal is contrary to the statutory intent.

Response: We appreciate the commenters' concern. However, while the maintenance of effort provisions of the statute explicitly speak to more restrictive income and resource standards and methodologies, they do not reference other conditions of eligibility or other State actions, such as dropping optional eligibility groups.

Prior to the enactment of SCHIP, the overwhelming majority of children under 19 who were eligible for Medicaid under an optional category received coverage under the States' medically needy programs. By that time, children previously covered under other optional groups largely had been subsumed by the mandatory poverty-related eligibility groups. Given the further recent expansion of eligibility under the poverty-related groups and through the use of less restrictive income and resource standards and methodologies permitted under section 1931 of the Act, the number of children in these other groups has further diminished. Most of the children who remain covered under an optional group--other than those in a medically needy group--fall into the optional categorically needy group of children eligible under section 1902(a)(10)(A)(ii)(I) of the Act, often referred to as "Ribicoff children."

Under section 1902(a)(10)(C)(ii)(I) of the Act, States cannot drop only children under 19 from their medically needy programs. It is highly unlikely that a State would drop its entire medically needy program in order to place a few children in SCHIP. Since the number of children in other optional eligibility groups is very small, there is little financial incentive for States to drop any of these groups either. The only reason a State might potentially drop one of its optional groups would be to cover the children under another, broader group. Such simplifications likely will promote enrollment of children and should not be discouraged.

In this context, two additional points are pertinent to understanding our decision. First, under the proposed regulation, States that eliminate an optional eligibility category will not be able to receive the enhanced FMAP for any children who would have been eligible for Medicaid under the eligibility standards for the dropped group in effect on March 31, 1997. Thus, the proposed regulations do not permit States to transfer any children from coverage under an optional Medicaid group to a stand-alone SCHIP program or to receive enhanced FMAP for such children under a Medicaid expansion. States simply would not be precluded from receiving the enhanced match for *other* children in its SCHIP program, which is what

would happen if a State reduced coverage under a mandatory category.

Second, all Ribicoff children under age 19 will be subsumed by the mandatory poverty-level group by October 1, 2002, so any savings generated from eliminating this group, which, as discussed above would be nominal, would also be short-lived.

Accordingly, there is little incentive for States to eliminate any non-medically needy eligibility categories under Medicaid. In the highly unlikely event that a State nonetheless chose to do so, the number of children who would be affected would be minimal. The small number of potentially (but unlikely to be) affected children does not justify restricting States' ability to simplify their Medicaid programs in this regard.

Comment: One commenter requested that we add "with or without creditable insurance" to §433.11(a)(2), to make it clear that the enhanced FMAP is available for children born before October 1, 1983 who would be described in section 1902(l)(1)(D) of the Act (the poverty-level children's group) if they had been born on or after that date and would not qualify for medical assistance under the State plan in effect on March 31, 1997, even if they have creditable health coverage.

Response: We have added "with or without group health coverage or other health insurance coverage" to §433.11(a)(2) to clarify this point.

5. Optional targeted low-income children (§435.229)

Section 4911 of the BBA amended the Social Security Act by adding a new section 1902(a)(10)(A)(ii)(XIV) to establish an optional categorically-needy group of children referred to as "optional targeted low-income children," and described in section 1905(u)(2)(C) of the Act. Section 1905(u)(2)(C), as added by section 4911 of the BBA, was subsequently revised by section 162 of Public Law 105-100 and, in the process, "(C)" was changed to "(B)". In an apparent oversight, no conforming change was made to section 1902(a)(10)(A)(ii)(XIV) of the Act to refer to section 1905(u)(2)(B), rather than to 1905(u)(2)(C). Since it appears that this was simply a drafting error, we consider the reference to 1905(u)(2)(C) in this section to be a reference to 1905(u)(2)(B).

Section 1905(u)(2)(B) defines an optional targeted low-income child as a child who meets the definition of a targeted low-income child in section 2110(b)(1) of title XXI of the Act and who would not qualify for Medicaid under the Medicaid State plan in effect on March 31, 1997. Because only a child under 19 can qualify as a targeted low-income child under section 2110(b)(1) of the Act (see section 2110(c) of the Act), to be covered as an optional targeted low-income child under Medicaid, an individual also must be under 19 (even though individuals

between 19 and 21 can qualify for Medicaid under other eligibility groups).

The very specific cross reference in section 1905(u)(2)(B), to section 2110(b)(1), for the definition of an optional targeted low-income child indicates that the Medicaid definition of "optional targeted low-income child" is based only on section 2110(b)(1). Thus, the definition of "targeted low-income child" for Medicaid does not include the exclusions described in section 2110(b)(2) that apply to the definition of "optional targeted low-income child" for separate child health programs under title XXI. Specifically, the following groups of children are excluded from eligibility for a separate child health program under title XXI, but are not excluded from eligibility for Medicaid: 1) children who are inmates of public institutions and patients in institutions for mental diseases (IMD); and 2) children who are eligible for health benefits coverage under a State health benefits plan on the basis of a family member's employment with a public agency in the State.

Under existing Medicaid eligibility rules, there is no eligibility exclusion for children who are inmates of a public institution, patients in an IMD, or children eligible for health benefits coverage under a State health benefits plan on the basis of a family member's employment with a public agency in the State, although restrictions on Federal financial participation

(FFP) apply under some circumstances. Specifically, no FFP is available under Medicaid for services provided to inmates of public institutions or patients in an IMD. We note that under Medicaid, if, under section 1905(a)(16) of the Act, a State elects to cover inpatient psychiatric services for individuals under age 21, FFP is available for services furnished to children in psychiatric facilities for individuals under age 21 that meet certain standards and conditions (see §441.150ff).

Turning to the proposed rule, the definition of optional targeted low-income child at section 1905(u)(2)(B) of the Act excludes children who would have been eligible for medical assistance under the State plan in effect on March 31, 1997 on any basis, thus including those who would have been eligible under a State's medically needy group. This exclusion was set forth in proposed §435.229(a)(2). We explained in the preamble to the proposed rule that we would interpret section 1905(u)(2)(B) to exclude children who would have been eligible as medically needy based on their current financial status without a "spend-down," an amount that can be spent on medical care before the child can become eligible. However, children who would have been eligible for Medicaid under the State plan in effect on March 31, 1997 only after paying a spend down would not be excluded, because they would not have been eligible for Medicaid until the spend-down had been met.

We explained in the preamble for proposed §435.229 that the regular Medicaid financial methodologies that govern eligibility of children in a State, that is, the income and resource methodologies under the State's AFDC plan in effect on July 16, 1996, must also be used to determine whether a child is eligible under the new group of optional targeted low-income children. However, a State may use the authority of section 1902(r)(2) of the Act to adopt less restrictive methods of determining countable income and resources for this group.

States that choose to cover a group of optional targeted low-income children also must apply uniform income and resource eligibility standards for the group throughout the State. States also are required to provide all services covered under the plan, including EPSDT services, to optional targeted low-income children. Indeed, as we explained in the preamble to the proposed rule, States must apply all regular Medicaid rules. We thought it worth emphasizing that this includes Medicaid rules pertaining to immigration status.

States are not required to provide coverage to all children who meet the definition of an optional targeted low-income child. As with the existing Medicaid rules, eligibility under the optional group can be limited to a reasonable group or reasonable groups of such children. However, this option, reflected in proposed §435.229(b)(2), does not allow States to limit a group

by geographic location because of the requirement in section 1902(a)(1) of the Act that a State plan be in effect in all political subdivisions of the State. Also, as explained in the preamble to the proposed rule, we do not consider it reasonable to limit a group by age other than by those age groups specified by Congress in section 1905(a)(1) and referenced in section 1902(a)(10)(A)(ii). We believe that if Congress had intended to allow other uses of age to establish categories of eligibility, the statute would not have specified any age groups. We note that, in the case of the group of optional targeted low-income children, a State does not have the option to cover a reasonable category of children under age 21 or 20, because for purposes of defining "targeted low-income child" for title XXI programs and "optional targeted low-income child" for Medicaid expansion programs, "child" is defined in section 2110(c)(1) of the Act as a child under age 19. (This age limitation applies to all optional targeted low-income children, not only those in the optional group.)

Section 2110(b)(1)(B) refers to the Medicaid applicable income level, which, under 2110(b)(4), explicitly recognizes potentially different levels based upon the age of a child. The income standard for the optional categorically-needy group of optional targeted low-income children may be different for infants, children under age 6, and children between ages 6 and 18

(that is, under age 19) if the State's Medicaid applicable income levels for these age groups differ.

We did not propose to require or allow States to apply eligibility-related private health insurance substitution provisions, such as periods of uninsurance, to the "optional targeted low-income children" group because such eligibility conditions are inconsistent with the entitlement nature of Medicaid and are therefore not permitted by the Medicaid statute in the absence of a section 1115 waiver.

Finally, we explained in the preamble to the proposed rule that States are obligated to continue to provide services to eligible optional targeted low-income children after its title XXI allotment is exhausted, unless the Medicaid State plan is amended to drop the group of optional targeted low-income children. Once the title XXI allotment is exhausted, Medicaid matching funds are available for these children at the regular matching rate rather than the enhanced rate.

Comment: Two commenters requested that the Medicaid regulations include a definition of optional targeted low-income child because they found the cross-reference to the title XXI regulations is confusing. They also noted that some provisions in title XXI, such as permitting States to limit eligibility by geographic region, do not apply in Medicaid.

Response: We accept the commenters' request to clarify the definition of optional targeted low-income child in the Medicaid regulations, rather than cross-reference §457.310(a). In proposed §435.229(a), the cross-reference to §457.310(a) resulted in the inclusion of some provisions of the definition of targeted low-income child that only apply to separate child health programs. Therefore, we have removed the cross-reference in §435.229 to §457.310(a) and added a Medicaid-specific definition of optional targeted low-income child to §435.4 (for the States, the District of Columbia, the Northern Mariana Islands, and American Samoa) and to § 436.3 (for Guam, Puerto Rico, and the Virgin Islands). The definition of optional targeted low-income child applies to the optional categorically needy group of optional targeted low-income children under §435.229 and §436.229 for whom the enhanced FMAP is available.

Specifically, §§435.4 and 436.3 include the following children in the definition of "optional targeted low-income child": (1) children who have family income at or below 200 percent of the Federal poverty line for a family of the size involved; (2) children who reside in a State which does not have a Medicaid applicable income level, as that term is defined in §457.10; or (3) children who reside in a State that has a Medicaid applicable income level and has a family income that exceeds the Medicaid applicable income level for the age of such

child, but not by more than 50 percentage points; or (4) children whose income does not exceed the effective income level specified for such child to be eligible for medical assistance under the policies of the State plan under title XIX on June 1, 1997. As noted, we have revised the definition to clarify that an optional targeted low-income child that resides in a State that has a Medicaid applicable income level may have family income that exceeds the Medicaid applicable income level, but does not exceed the effective income level that has been specified under the policies of the State plan under title XIX on June 1, 1997. This provision effectively allows children who became eligible for Medicaid as a result of an expansion after March 31, 1997 but before June 1, 1997 may be considered optional targeted low-income children. It also means that children who were below the Medicaid applicable income level, but were not Medicaid eligible due to financial reasons that were not related to income (for example, due to an assets test) can be covered by SCHIP.

Furthermore, the definition in §435.4 and §436.3 requires that an optional targeted low-income child must not be: 1) eligible for Medicaid under the policies of the State plan in effect on March 31, 1997; or 2) covered under a group health plan or under health insurance coverage unless the health insurance coverage program is offered by the State, has been in operation since before July 1, 1997, and the State receives no Federal

funds for the program's operation. A child would not be considered covered under a group health plan if the child did not have reasonable geographic access to care under that plan. These criteria mirror the provisions of proposed §457.310, except those that apply only to separate title XXI child health programs.

Comment: Three commenters indicated that children who were covered by section 1115 demonstration projects with a limited benefit package should not be considered to have been recipients of Medicaid, and therefore should not be excluded from the definition of optional targeted low-income children. They urged HCFA to provide a regulatory clarification so that children eligible under a section 1115 demonstration project that only provided a limited range of services would be eligible for enhanced matching under the definition of an "optional targeted low-income child."

Response: We agree with the commenters and have therefore revised the definition of the term "Medicaid applicable income level" at §457.10, to address their concerns. Specifically, in §457.10 we clarify that, for purposes of the definition of "Medicaid applicable income level," the term "policies of the State plan" includes policies under most section 1115(a) Statewide demonstration projects; however, the term does not include section 1115(a) demonstrations that granted coverage to a new group of eligibles but which did not provide inpatient

hospital coverage, or which limited eligibility both by allowing only children who were previously enrolled in Medicaid to qualify and imposing premiums as a condition of participation in the demonstration. This exception does not apply to waivers that extended the time period or conditions under which an individual could receive transitional medical assistance.

The exclusion of children eligible for medical assistance under the State plan in effect as of March 31, 1997 was intended to ensure that States did not transfer coverage of low-income children who would have been eligible under their Medicaid program at the regular Federal matching rate to the enhanced matching rate established by SCHIP. However, this provision does not specifically address the treatment of children who could have been covered under a section 1115 demonstration project in effect on March 31, 1997.

Our understanding is that the provision was not intended to preclude States from claiming enhanced matching funds for expanded coverage to children whose income is below the demonstration project eligibility thresholds in place as of March 31,1997, if those programs did not offer comprehensive coverage or limited eligibility to individuals who were previously enrolled in Medicaid and imposed premiums as a condition of participation. Demonstrations that had these types of restrictions are significantly more limited in scope (either in

coverage or eligibility) than “traditional” Medicaid programs. Our experience with SCHIP and our increased understanding of how this provision is affecting States’ ability to expand coverage have led us to agree with the commenters that an overly broad interpretation of the exclusion contained in section 1905(u)(2)(B) of the Act would be contrary to the intent of the statute. Furthermore, because enrollment in these types of demonstrations is relatively small, any supplantation of State dollars would be minimal. Therefore, we have clarified this provision in the final rule.

Comment: Several commenters supported the proposal that EPSDT policies apply to optional targeted low-income children. One of these commenters also agreed that there should not be a required period of uninsurance for these children and encouraged HCFA to explicitly prohibit such a requirement.

Response: EPSDT applies to this group of children because they are in a Medicaid group and entitled to all benefits and protections provided to children under Medicaid law and regulations. With respect to periods of uninsurance, we have not included the prohibition against requiring a period of uninsurance in the regulation text for this provision since periods of uninsurance are already prohibited by the Medicaid statute and regulations. We believe that this prohibition is inherent in the entitlement nature of Medicaid. States may not

impose conditions of eligibility other than those specifically allowed by statute, regulation, or waiver. We will work with States that have such policies in place to assure that the requirements of the statute are met.

6. Furnishing a Social Security number (§435.910)

Section 1137(a)(1) of the Act requires applicants and recipients of Medicaid to furnish the State with their social security number(s) as a condition of eligibility. While the United States Supreme Court in Bowen v. Roy, 476 U.S. 693 (1986) upheld this requirement, it did so in a plurality decision in which some of the Justices held that the challenge was moot because the claimant had obtained a social security number. As a result, that decision did not foreclose someone else with religious objections to applying for a social security number from challenging the constitutionality of section 1137(a)(1) of the Act. The Religious Freedom Restoration Act of 1993 also raised questions about the requirements of section 1137(a)(1) of the Act in cases involving religious objections.

Consequently, in 1995 HCFA announced a policy that permits States to obtain or assign alternative identifiers to eligible individuals who object to obtaining an SSN on religious grounds. This policy was adopted in order to enable States to administer Medicaid in the most efficient manner possible. In §435.910 of the proposed rule we attempted to accommodate the purpose of

section 1137(a)(1) with the Constitution's protection of freedom of religion and the dictates of the 1993 Act by permitting alternative identifiers.

We received no comments on this section. However, we wish to clarify that the statute requires an SSN of applicants and recipients only. States may request but may not require other individuals in the household to provide their SSN's. For example, if application is made on behalf of a child and the parent is not applying, the State may request the parent's SSN but must note that the SSN is not required and may not deny the child's eligibility if the parent does not provide his/her own SSN.

7. FFP for services and FFP for administration (§435.1001 and §435.1002)

Section 1920A of the Act allows States to provide services to children under age 19 during a period of presumptive eligibility. The implementation of this provision is discussed below. In accordance with this new option, we proposed to amend §435.1001 to provide FFP for necessary administrative costs incurred by States in determining presumptive eligibility for children and providing services to presumptively eligible children. In §435.1002 we proposed to provide FFP for services covered under a State's plan which are furnished to children during a period of presumptive eligibility. We received no

comments on either of these sections and are implementing them as proposed.

8. Exemption from the limitation on FFP for categorically needy, medically needy, and qualified Medicare beneficiaries (§435.1007)

Section 162 of Public Law 105-100 amended 1903(f)(4) of the Act to add the optional group of optional targeted low-income children and other children for whom enhanced FMAP is available to the list of those who are exempt from the limitations on FFP found in section 1903(f). All previous citations in section 1903(f) were references to Medicaid eligibility groups, whereas this new provision adds not an eligibility group per se, but rather children on whose behalf enhanced FMAP is available.

With certain exceptions, section 1903(f) limits FFP to families whose income does not exceed 133 1/3 percent of the amount that ordinarily would have been paid to a family of the same size without any income or resources, in the form of money payments under the Aid to Families with Dependent Children program. This provision effectively limits the use of the authority under section 1902(r)(2) to expand eligibility through the use of less restrictive income and resource methodologies for those groups that are not exempt from the limitation.

However, section 162 of Public Law 105-100 could result in extending the exemption from the FFP limitation to children other

than (1) children in the optional eligibility group of optional targeted low-income children or (2) children in other groups already exempt from the FFP limitation. If this were to occur, a conflict with the comparability requirements of section 1902(a)(17) and §435.601(d)(4) of the Medicaid regulations could arise. If, for example, a State sought to use more liberal income methodologies for counting income in determining the medically-needy eligibility of optional targeted low-income children than used for counting income in determining the medically-needy eligibility of other children, the comparability requirements would be violated.

Because the exemption from the FFP limit did not override the comparability requirement of the Medicaid statute, we proposed to continue to apply the FFP limitations described in §435.1007 to all children who are covered as medically-needy and to any optional categorically-needy group which is subject to the FFP limit. States may use more liberal methodologies under section 1902(r)(2) of the Act for the optional categorically-needy group composed exclusively of optional targeted low-income children without reference to the FFP limitations of section 1903(f). We received no comments on this section and have adopted this portion of the rule as proposed.

9. Presumptive eligibility for children (part 435, subpart L)

Section 4912 of the BBA added a new section 1920A to the Act to allow States to provide services to children under age 19 during a period of presumptive eligibility, prior to a formal determination of Medicaid eligibility. We set forth the basis and scope of subpart L in proposed §435.1100.

Under section 1920A of the Act, only a "qualified entity" can determine whether a child is presumptively eligible for Medicaid on the basis of preliminary information about the child's family income. In accordance with section 1920A(b)(3)(A) of the Act, we define a qualified entity in §457.1101 as an entity that is determined by the agency to be capable of making determinations of presumptive eligibility for children and that--(1) furnishes health care items and services covered under the approved Medicaid State plan and is eligible to receive payments under the approved plan; (2) is authorized to determine eligibility of a child to participate in a Head Start program under the Head Start Act; (3) is authorized to determine eligibility of a child to receive child care services for which financial assistance is provided under the Child Care and Development Block Grant Act of 1990; or (4) is authorized to determine eligibility of an infant or child to receive assistance under the special nutrition program for women, infants, and children (WIC) under section 17 of the Child Nutrition Act of 1966. In addition, the Benefits Improvement and Protection Act

of 2000 (BIPA) (P.L. expanded this list of qualified entities to include an entity that (5) is an elementary or secondary school, as defined in section 14101 of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 8801); (6) is an elementary or secondary school operated or supported by the Bureau of Indian Affairs; (7) is a State or Tribal child support enforcement agency; (8) is an organization that is providing emergency food and shelter under a grant under the Stewart B. McKinney Homeless Assistance Act; (9) is a State or Tribal office or entity involved in enrollment in the program under Part A of title IV, title XIX, or title XXI; or

(10) is an entity that determines eligibility for any assistance or benefits provided under any program of public or assisted housing that receives Federal funds, including the program under section 8 or any other section of the United States Housing Act of 1937 (42 U.S.C. 1437 et seq.) or under the Native American Housing Assistance and Self Determination Act of 1996 (25 U.S.C. 4101 et seq.); or (11) any other entity the State so deems, as approved by the Secretary.

Finally, section 1920A(b)(3)(B) also authorizes the Secretary to issue regulations further limiting those entities that may become qualified entities. We note that, although State agency staff can receive and process applications for regular Medicaid, they cannot make presumptive eligibility determinations

unless they themselves meet the definition of a “qualified entity” under §457.1101.

We note that the date that the completed regular Medicaid application form is received by the Medicaid State agency is the Medicaid filing date for Medicaid eligibility, unless State agency staff are located on site at the qualified entity, in which case the Medicaid filing date is the date that the onsite State agency staff person receives the completed form. Alternatively, the State can opt to consider the date the determination of presumptive eligibility is made as the Medicaid application date.

In accordance with section 1920A(b)(2), we also proposed in §435.1101 that the period of presumptive eligibility begins on the day that a qualified entity makes a determination that a child is presumptively eligible. The child would then have until the last calendar day of the following month to file a regular Medicaid application with the Medicaid agency. If the child does not file a regular Medicaid application on time, presumptive eligibility ends on that last day. If the child files an application for regular Medicaid, presumptive eligibility ends on the date that a determination is made on the regular Medicaid application.

Finally, proposed §435.1101 defined “applicable income level” as the highest eligibility income standard established

under the State plan which is most likely to be used in determining the Medicaid eligibility of the child for the age involved. We note that there may be different applicable income levels for children in different age groups. For example, the standards for presumptive eligibility might be 133 percent of the Federal poverty level (FPL) for children under 6 and 100 percent FPL for children age 6 through 19, if these were the highest standards applicable to children of the specified ages under a State's Medicaid plan.

We proposed in §435.1102(a) to provide limited flexibility to States in calculating income for purposes of determining presumptive eligibility. We also explained in the preamble to the proposed rule that under §435.1102(a) we would allow States to require that qualified entities request and use general information other than information about income, as long as the information can be obtained through the applicant's statements and is requested in a fair and nondiscriminatory manner. With respect to income, in States that adopt the most conservative approach to presumptive eligibility, the qualified entity would use gross family income. The qualified entity would compare gross family income to the applicable income level, as defined in §435.1101.

For States wishing to adopt a more liberal approach, however, we specifically proposed to allow States to require that

qualified entities apply simple income disregards, such as the general $90 earned income disregard. However, as explained in the preamble we did not propose to allow States to require that qualified entities deduct the costs of incurred medical expenses in order to reduce income to the allowed income level. We solicited comments on whether States should be allowed to require that qualified entities make certain adjustments to gross income and ways that these adjustments could be limited.

Proposed §§435.1102(b)(1) and (b)(2) implement the provisions of section 1920A(b)(1) of the Act. Section 435.1102(b)(1) requires that States provide qualified entities with regular Medicaid application forms (defined in proposed §435.1101) as well as information on how to assist parents, guardians, and other persons in completing and filing such forms. At a minimum, we proposed that States must furnish qualified entities with the applications used to apply for Medicaid under the poverty-related groups described in section 1902(l)(1) of the Act.

Proposed §435.1102(b)(2) requires States to establish procedures to ensure qualified entities--(1) notify the Medicaid agency that a child is presumptively eligible within 5 working days; and (2) provide written information to parents and custodians of children determined to be presumptively eligible, explaining that a regular Medicaid application must be filed by

the last day of the following month in order for the child to continue to receive services after that date and that if an application is timely filed on the child's behalf, the child will remain presumptively eligible until a determination of the child's eligibility for regular Medicaid has been made; and (3) provide written information to parents and custodians of children determined not to be presumptively eligible of the reason for the determination and that the child has a right to apply to regular Medicaid.

While we are requiring such notification, we are considering presumptive eligibility to be a special status, distinct from regular Medicaid eligibility. Therefore, we did not propose to apply to a decision on presumptive eligibility the notification requirements, found in §§435.911 and §435.912 and part 431, subpart E, that a State must meet when it makes a decision on a regular Medicaid application. Nor did we propose to grant rights to appeal a denial or termination of services under a presumptive eligibility decision because a determination of presumptive eligibility is not considered to be a determination of Medicaid eligibility. If a regular Medicaid application is filed on the child's behalf and is denied, the child would have the right to appeal that denial.

Because presumptive eligibility is a special status, we considered whether States should be required to provide all

services to presumptively eligible children or whether they should be permitted to limit the services provided. In §457.1102(b)(3), we proposed to require that States provide all services covered under the State plan, including EPSDT, to presumptively eligible children.

Although section 1920A places no restrictions on the number of periods of presumptive eligibility for a child, it undermines the intent of the provision to provide a child with an unrestricted number of periods. Therefore, we proposed in §435.1102(c) to allow States to establish reasonable methods of limiting the number of periods of presumptive eligibility that can be authorized for a child in a given time frame. We solicited comments on what would constitute a reasonable limitations and whether specific limitations on the number of periods of presumptive eligibility should be imposed by regulation.

Existing regulations at §435.914 permit States to provide Medicaid for an entire month when the individual is eligible for Medicaid under the plan at any time during the month. However, as explained in the preamble to the NPRM, because a determination of presumptive eligibility is not, by definition, a determination of Medicaid eligibility, but simply a decision of temporary eligibility based on a special status, and because section 1920A(b)(2) of the Act expressly defines the period of

presumptive eligibility, we did not propose to permit States to provide full-month periods of presumptive eligibility.

Section 4912 of the BBA provides that, for purposes of Federal financial participation, services that are covered under the plan, furnished by a provider that is eligible for payment under the plan, and furnished to a child during a period of presumptive eligibility, will be treated as expenditures for medical assistance under the State plan. This provision is reflected in proposed §435.1001. We note that in the event that a child determined to be presumptively eligible is not found eligible for Medicaid after a final eligibility determination, the services provided during the presumptive eligibility period that otherwise meet the requirements for payment will be covered. See §447.88 and §457.616 for a discussion of the options for claiming FFP payment related to presumptive eligibility.

Comment: We received one comment that the regulations should clarify that a State can provide a joint SCHIP/Medicaid application or a shortened Medicaid application used for pregnant women and children as well as a "regular Medicaid application."

Response: We agree that a qualified entity may provide parents and caretakers with either a shortened application that is used to establish eligibility for pregnant women and children under the poverty-level-related groups described in section 1902(l) of the Act or a joint application for a separate child

health program and Medicaid that is used to establish eligibility of children. We have revised the definition of "application form" in §435.1101 to include the a joint SCHIP/Medicaid application for a Medicaid and a separate child health program.

We would like to clarify that, under Federal law, no application form for presumptive eligibility itself is required. Thus, qualified entities can make presumptive-eligibility determinations based strictly on oral information. (The qualified entity would need to record the pertinent information, but the parent or caretaker (or other responsible adult) would not themselves need to complete an application.) This would not preclude qualified entities from assisting families in completing and filing the regular Medicaid application to the extent permitted under law, and we strongly encourage them to do so.

Alternatively, a State may choose to use a written application for presumptive eligibility, although it cannot require the parent or caretaker to provide information other than the information on income necessary to make the determination.

We encourage States that choose to use a written application, particularly those with simplified Medicaid application forms, to use the same form for presumptive eligibility as that used for regular Medicaid, as this will eliminate the need for the child's family to complete two forms.

The parent or caretaker can be encouraged to complete the application and assisted in doing so. But, again, so long as pertinent information on income is provided, presumptive eligibility in a State that has elected this option cannot be denied because the full application is not completed.

In either event, of course, the State must provide qualified entities with information on how to assist families in completing and filing the application and ensure that they give presumptive-eligibility applicants a Medicaid application form. We also strongly encourage States, in turn, to encourage qualified entities to provide such assistance to the extent permitted under Medicaid law and regulations.

Comment: One commenter specifically supported the requirement that presumptive eligibility must be provided Statewide and one commenter specifically objected to this requirement. A third commenter objected to requiring each qualified entity to conduct Statewide presumptive eligibility outreach and determination.

Response: We have considered the commenters' suggestions and have retained proposed §435.1102(b)(4) related to Statewide availability of presumptive eligibility. Section 1920A(b)(3)(C) provides States with the authority to limit the classes of entities that may become qualified entities; and therefore may limit the population that have the opportunity to become

presumptively eligible. For example, States could designate WIC agencies to make determinations of presumptive eligibility only for the clients who have applied for or are receiving WIC, but all of the WIC agencies across the State would be required to offer presumptive eligibility. Therefore, a State could effectively limit the availability of presumptive eligibility by designating particular qualified entity to offer it.

Comment: One commenter noted that schools would not be able to do determinations of presumptive eligibility for pre-schooled, home-schooled, drop-outs or graduates.

Response: Although schools are not likely to be in regular contact with children falling into one of these groups, and as a practical matter may not be in a position to make presumptive eligibility decisions for them, schools that are Medicaid providers would not be precluded from determining the eligibility of a child simply because the child did not attend the school. Thus, schools would also be authorized to determine the presumptive eligibility of the children identified by the commenter.

Comment: We received one comment concerning verification of information used to determine presumptive eligibility. The recommendation was that the regulations specifically require that “self-attestation” be used for determinations of presumptive eligibility if income disregards are used and that in other

cases, HCFA encourage States to allow applicants to attest to information required for a determination of presumptive eligibility without providing documentation.

Response: We have revised §435.1102 to make it clear that an estimate of income is to be used for purposes of presumptive eligibility determinations even when a State has chosen to apply simple disregards. The statute provides that determinations of presumptive eligibility are based on "preliminary information" and we do not believe that requiring documentation is consistent with the intent that the process be simple for both the applicant and the provider and result in immediate eligibility. Therefore, an applicant's self-attestation as to income is all that would be required to establish the amount of income for presumptive eligibility determinations, regardless of whether income disregards are used or not. This is consistent with the proposed rules pertaining to presumptive eligibility for pregnant women, published March 23, 1994 (59 FR 13666).

Comment: One commenter specifically supported allowing only simple disregards in determinations of presumptive eligibility. Another commented that States should be free to decide whether to use gross or net income for determinations of presumptive eligibility.

Response: We appreciate the support and agree in part with the second commenter. States are free to use only gross income.

States may also apply simple disregards to gross income such as a general earned income disregard. However, it would not be consistent with statutory intent to allow States to require that qualified entities apply complicated income disregards or make complicated determinations. Therefore, we have not revised proposed §457.1102(a) in this final regulation.

Comment: Three commenters expressed support for requiring that, in proposed §457.1102(b)(3), presumptive eligibility include EPSDT services. One of these commenters urged that the preamble discuss the steps that States should take to assure that EPSDT services are provided.

Response: We are not including any specific EPSDT guidance in this regulation. The regular Medicaid policies which pertain to EPSDT, including policies about providing information about EPSDT services to families and generally informing families about the benefits of preventive health, would apply when a child is found presumptively eligible for Medicaid.

Comment: We received several comments concerning written notices provided to the family and the responsibilities of qualified entities. One comment was that it would be difficult for schools to issue the notice of presumptive eligibility and the temporary enrollment card and the State should be allowed to do this instead. Another was that it would be difficult for schools to send a written notice to those found not to be

presumptively eligible and might result in the family's confusion and anger. One comment was that, generally, HCFA should encourage States to develop procedures that are not burdensome to providers, provide adequate training and provider relations, and keep the provider apprized of the status of the application so that, if not completed at the time of any follow-up visit, the provider can encourage the family to complete the process, as necessary.

Response: Our understanding is that the intent of the legislation is to minimize the burden placed on qualified entities, including schools and other providers. However, the statute specifically requires that the qualified entity inform the family that an application for Medicaid must be filed by the end of the following month. It is also clear that qualified entities are expected to provide Medicaid applications and assistance in completing and filing such applications. We certainly encourage States to simplify the presumptive eligibility process to the greatest extent allowed under the law. It is not unnecessarily burdensome for the qualified entity to provide written notices to those found presumptively eligible or ineligible, as these notices could be pre-printed notices provided by the State.

Although we have not required it, it would not be unnecessarily burdensome for a State to require a qualified

entity to provide a temporary enrollment card to enable the child to access services during the period of presumptive eligibility particularly when the qualified entity itself does not provide medical services. We also encourage States to keep qualified entities apprized of the status of the child's application if the entity is willing to follow up with families whose application has not been completed.

Comment: One commenter suggested that §435.1102(b)(2)(iii) should be amended to require that qualified entities tell individuals who are not found presumptively eligible for Medicaid that they may file for coverage under a separate child health program as well as Medicaid and provide applications for both programs as well as information on how to complete and file them.

Response: We have not required that qualified entities provide information about a separate child health program. However, we encourage States to do this as part of their outreach programs and coordination efforts. In addition, as noted above, we have amended §435.1101 to make it clear that the application provided by a qualified entity may be a joint Medicaid/SCHIP application.

Comment: One commenter urged HCFA to encourage States to simplify the enrollment process and provide prompt, easy-to-understand information to the family about the eligibility determination process and any remaining steps that the family

must take. Another expressed concern that States are not required to send a notice at the end of a presumptive-eligibility period, which would alert families who sent in a Medicaid application that was never received.

Response: HCFA has encouraged States to simplify both the eligibility requirements and the enrollment procedures to the greatest extent possible and will continue to do so. We also encourage States to make all information provided to families understandable and will provide technical assistance in this area. We encourage States to notify families that the child's presumptive eligibility will be terminated and that no Medicaid application has been received. We also encourage States to establish other procedures to follow-up with families of presumptively-eligible children early on in the presumptive-eligibility period. However, requiring States to do so is beyond the intent of the statute, and could discourage some States from adopting presumptive eligibility for children at all. We will not mandate that States institute such procedures.

Comment: We received several comments in response to our specific request related to limitations on the number of periods of presumptive eligibility available to a child. One commenter believed that no more than one period of presumptive eligibility within 24 months would be reasonable, but recommended that States be allowed to set their own standards. Another commenter agreed

it would be unreasonable to provide unlimited periods of presumptive eligibility, but believed that it would be reasonable to allow only one period per lifetime. A third recommended that there be no lifetime limit on the number of periods, but a limit on the number of periods within a specific time-frame (for example, one period of presumptive eligibility within a twelve-month period). A final commenter believed that it would be difficult for providers, who are considered qualified entities, to track the number of presumptive-eligibility any child has enjoyed.

Response: We have decided to require that States adopt reasonable standards regarding the number of periods of presumptive eligibility that will be authorized for a child within a given period of time. Under some circumstances, more frequent or numerous periods of presumptive eligibility may be justified and individual circumstances may be taken into account. We are not requiring that States establish a specific maximum number of periods for specific time frames in this final regulation. We realize that the circumstances that result in a need for an additional period of presumptive eligibility will vary greatly from case to case. In addition, States may wish to have some experience before setting up a standard that qualified entities must follow. We expect States to monitor the use of presumptive eligibility to determine whether there is a need for

specific limitations on the number of periods of presumptive eligibility to which a child is entitled.

We appreciate the support for our position that it would be unreasonable to provide unlimited periods of presumptive eligibility. However, if a State decides to establish set limits, we do not agree that one period of presumptive eligibility in a lifetime is reasonable given the changes in a child's circumstances that may occur over time. It would be reasonable, however, to limit the periods of presumptive eligibility to one per twelve or twenty-four month period, as suggested. Furthermore, it would be reasonable to connect limitations on presumptive eligibility to the length of time during which a child is not covered by Medicaid. For example, a State could prohibit an additional period of presumptive eligibility until the child had been disenrolled from Medicaid for a certain period of time. In response to the last commenter, after a State has established how it will restrict the number of periods of presumptive eligibility, we expect that the State will develop procedures for assuring that the restrictions are applied without unduly burdening the qualified entities, including providers.

L. Medicaid Disproportionate Share Hospital (DSH) Expenditures

Section 4911 of the BBA amended section 1905(b) of the Act to require that for expenditures under section 1905(u)(2)(A)(that

is, medical assistance for optional targeted low-income children) or section 1905(u)(3) (that is, medical assistance for children referred to as “Waxman children”), the Federal medical assistance percentage is equal to the enhanced FMAP described in section 2105(b)of the Act unless the State has exhausted its title XXI allotment, in which case the State’s regular FMAP would apply. In other words, under the statute, States that provide health insurance coverage to children as an expansion of their Medicaid programs may receive an enhanced match for services provided to the Medicaid expansion population.

Under the authority of section 1902(a)(13)(A)(iv) of the Act, States are required to take into account the situation of hospitals that serve a disproportionate number of low-income patients with special needs when developing rates for Medicaid inpatient hospital services. Medicaid disproportionate share hospital (DSH) expenditures thus are payments made for hospital services rendered to Medicaid-eligible patients. Depending on the State’s DSH methodology, some of the payments may be directly identifiable as expenditures for services for a child in a SCHIP-related Medicaid expansion program. HCFA concluded in the proposed rule that those identifiable payments must qualify for the enhanced FMAP.

We further proposed §433.11 which set forth provisions regarding the enhanced FMAP rate available for State DSH

expenditures related to services provided to children under an expansion to the State’s current Medicaid program. However, based on the statutory changes included in the “Medicare, Medicaid, and CHIP Balanced Budget Refinement Act of 1999," this section is being deleted. Specifically, H.R. 3426 incorporated changes to section 1905(b) (42 U.S.C. 1396d(b)) by inserting the phrase “other than expenditures under section 1923," after “with respect to expenditures.” By inserting this phrase, the statute specifically excludes Medicaid DSH expenditures from qualifying for enhanced FMAP.